Tennessee CoverRx

Express Scripts Specialty Distribution Services, Inc.
P. O. Box 66979
St. Louis, MO 63166-6979

EXPRESS SCRIPTS®

APPLICATION FOR ENROLLMENT (Do not complete this form if you are under the care of a Community Mental Health Agency)

Applicant Information - All fields must be complete or application will be returned (unless noted as optional)

Last Name	First Name	MI	Gender M F	Date of Birth	Social Security Number

Race (Optional)	Language Spoken (Optional)	Annual Household Income	# of People in Household	Phone Number (Write N/A if you do not have a phone)
□ Black: Hispanic or Non Hispanic □ White: Hispanic or Non Hispanic □ Asian / Pacific Islander □ American Indian / Alaskan □ Mixed Ethnicity □ Other _____	□ English □ Spanish □ Other _____			

Home Address	City	State	Zip Code
Mailing Address (if different from above)	**City**	**State**	**Zip Code**

Please answer all questions below:

□ Yes □ No Are you a U.S. citizen or qualified alien?

□ Yes □ No Have you been a Tennessee resident for at least the last six months?

□ Yes □ No Do you currently have health insurance (including TennCare)?

□ Yes □ No Do you currently have prescription drug coverage (including Medicare, TennCare, or employer sponsored drug coverage)?

□ Yes □ No Are you homeless or living in a shelter? (Optional)

□ Yes □ No Are you currently employed (including self-employed)? (Optional)

□ Yes □ No Do you work 20 hours or more in a seven day work week? (Optional)

Terms and Conditions

While you are in CoverRx, you must follow the program rules. By signing the front of this form, you agree that:

Event Code
460

You will pay your co-pay for each prescription filled.

You will call Express Scripts (program administrator) at 1-888-560-2649 when:

- You move to a new address
- Your household income changes significantly
- The number of people in your household changes
- You have prescription drug coverage

You will help with any investigations. CoverRx may ask you for proof of your household income. CoverRx may also ask you to provide proof that you live in Tennessee and/or that you are a U.S. citizen or qualified alien. You agree to provide this information to CoverRx. If you do not help, then you could lose your pharmacy assistance.

You allow CoverRx to get information about you. I understand that I have certain privacy rights with respect to my medical information under the Health Insurance Portability and Accountability Act (HIPAA), CFR Parts 160 and 164 ("Privacy Rule"). The Privacy Rule permits CoverRx to use and disclose my protected health information for purposes of treatment, payment and health care operations, including determining my eligibility for benefits.

You can report fraud or abuse. If you suspect someone of fraud or abuse please call the Office of Inspector General at 1.800.433.3982 or www.tncarefraud.tennessee.gov

Authorization: I want to apply for CoverRx pharmacy assistance. By signing below, I certify that the information contained in the application is true and accurate. I know that if I give any false information, I may be breaking the law. I know that CoverRx will check my information. I agree to help with any investigations. I also agree to follow the rules for the CoverRx program. I have read and understand these rules, which are on the back of this form.

Signature: _____ Date: _____

Eligibility

To be eligible to participate in CoverRx, you must meet the following eligibility guidelines:

- Age 19 through 64
- Household income must fall within Level 1, 2, or 3 listed below
- U.S. citizen or qualified alien
- Tennessee resident for at least the last six months
- No prescription drug coverage

How Much You Will Have to Pay

If you are enrolled in the program, CoverRx will help you pay for up to (5) prescriptions each month, in addition to diabetic supplies and insulin. You will be required to pay a small co-payment amount for your first (5) prescriptions each month. (Note: A 90-day prescription counts as (3) 30-day prescriptions.) You will have to pay the full amount for all prescriptions that exceed the monthly (5) prescription limit. CoverRx has negotiated pharmacy discounts to help you with the cost of these medications.

You must purchase your prescriptions at participating local community retail pharmacies and mail order pharmacies. Upon enrollment in the CoverRx program, an information packet will be sent to you with detailed information about how to use the program.

The co-payment amount for the first (5) prescriptions is based on your household income. See household income chart below to see which household income level you are in. This determines the amount of your co-payment.

	Co-Payments (For each medication. Up to 5 prescriptions per month)		
Drugs on the CoverRx list:	**Income Level 1** Generic: 30 day = $3 *90 day = $3 Insulin / Diabetic Supplies: 30 day (or up to covered limits) = $5	**Income Level 2** Generic: 30 day = $6 *90 day = $12 Insulin / Diabetic Supplies: 30 day (or up to covered limits) = $10	**Income Level 3** Generic: 30 day = $10 *90 day = $20 Insulin / Diabetic Supplies: 30 day (or up to covered limits) = $15
Drugs NOT on the CoverRx list and/or All prescriptions after the (5) prescription per month limit	Full payment of discounted price (price varies by drug)	Full payment of discounted price (price varies by drug)	Full payment of discounted price (price varies by drug)
	Annual Household Income Levels		
Persons in Household	**Income Level 1**	**Income Level 2**	**Income Level 3**
1	$0 - $9,799	$ 9,800 - $14,699	$14,700 - $24,500
2	$0 - $13,199	$13,200 - $19,799	$19,800 - $33,000
3	$0 - $16,599	$16,600 - $24,899	$24,900 - $41,500
4	$0 - $19,999	$20,000 - $29,999	$30,000 - $50,000
5	$0 - $23,399	$23,400 - $35,099	$35,100 - $58,500
6	$0 - $26,799	$26,800 - $40,199	$40,200 - $67,000
7	$0 - $30,199	$30,200 - $45,299	$45,300 - $75,500
8	$0 - $33,599	$33,600 - $50,399	$50,400 - $84,000
For each additional person, add	$3,400	$3,400	$5,100

Contact Information

Mail completed form to:	**Tennessee CoverRx** Express Scripts Specialty Distribution Services, Inc. P. O. Box 66979 St. Louis, MO 63166-6979
For questions about CoverRx:	1-888-560-2649

Definitions

"Discount" means a price reduction offered to participants for certain prescriptions.

"Household Income" is the combined income of all household members 18 years old and over who maintain a single economic unit, as well as any income received by the household for the personal medical and other obligations of the participant(s) in the household.

"Household" is comprised of all persons living in the same residence maintaining a single economic unit.

"Qualified alien" means that you are not a U.S. citizen, but you live in the United States legally. To be a qualified alien, you must also meet other conditions. These conditions are defined in the federal law at 8 U.S.C. § 1622(b). If you are not a U.S. citizen or qualified alien, then you cannot enroll in CoverRx.

*90-day supplies are only available through mail order and those local retail pharmacies that have chosen to participate. Before you fill your prescription, check with your pharmacy to see if the 90-day supply is available at that location.

CoverRx is managed by Express Scripts, Inc. (ESI), which among other things, owns and operates a mail order pharmacy. ESI does not accept returns of unused medicine, and fees are nonrefundable once ESI received your valid prescription. ESI will send your medicines to the address you choose. You are responsible for the package once it arrives.
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